BDDSO 147M 5/02

MINOR OCCURRENCE

1. OVERSIGHT AGENCY: OMRDD
2. LOCATION: B DC
3. PROGRAM TYPE:
4. ADDRESS: 888 Fountain Ave Bklyn NY 11208
5. PHONE: ( )

PART A – TO BE COMPLETED BY STAFF DESIGNATED IN POLICY

6. SUBJECT'S NAME (Last, First): Young Valarie
7. AGE: 33
8. SEX: ☐ Male ☒ Female
9. I. D. No: 6396

10. ADAPTIVE BEHAVIOR DEFICITS (X All Which Apply)
MODERATE: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
SEVERE: 6 ☒ Communications 7 ☐ Independent Living 8 ☐ Learning 9 ☐ Mobility 10 ☐ Self Direction

DEVELOPMENTAL DISABILITY
1 ☐ MR 2 ☐ Mild 3 ☐ Moderate 4 ☐ Severe 5 ☐ Profound
6 ☐ C.P.
7 ☐ Epilepsy
8 ☐ Autism
9 ☐ Neurological Impairment (Specify the impairment in #25

11. MEDICATION REGIMEN (X One Only)
1 ☐ None
2 ☐ Antibiotic Only
3 ☐ Psychotropic Only
4 ☐ Antiepileptic Only
5 ☐ Antibiotic-Psychotropic
6 ☐ Antibiotic-Antiepileptic
7 ☐ Psychotropic-Antiepileptic
8 ☐ Psychotropic-Antiepileptic-Antibiotic
9 ☒ Other

12. DATE & TIME OCCURRENCE WAS
1 ☒ Observed
2 ☐ Found

Mo.	Day	Year	Hour	Min.	
06	24	03	03	30	☐ A.M. ☒ P.M.

13. Number of other consumers with DD present at time of incident: 1
14. Number of Employees Present at time of incident: 1

15. CLASSIFICATION OF INCIDENT (X One)
1 ☐ Injury-Observed
2 ☐ injury-Found
3 ☐ Medication Error
4 ☐ Physical Intervention
5 ☐ Chemical Restraint
6 ☐ Altercation between 2 consumers
7 ☐ Bite
8 ☐ LWOC
9 ☒ Other (Specify in #21)

16. CAUSES OF INCIDENT (X All Which Apply)
1 ☐ Action of Consumer (See #19)
2 ☐ Physical Handicap
3 ☐ Seizure/Fainting
4 ☐ Fall
5 ☐ Physical Intervention
6 ☐ Actions of Other Consumers
7 ☐ Actions of Employee
8 ☐ Actions of Visitor
9 ☐ Hazardous Conditions on Facility Property
10 ☐ Faulty, Inadequate or Inappropriate Equipment
11 ☒ Other (Specify in #21)

17. LOCATION OF INCIDENT
1 ☒ Indoors 2 ☐ Outdoors

18. SPECIFIC LOCATION
1 ☒ Living Room
2 ☐ Bedroom
3 ☐ Kitchen
4 ☐ Bathroom
5 ☐ Hallway
6 ☐ Staircase
7 ☐ Dining Room
8 ☐ Program Room
9 ☐ Recreation Area
10 ☐ Off Facility Property
11 ☐ Other (Specify in #21)

19. ACTIONS OF SUBJECT OF REPORT (X One Only if Box #1 in Item 16 was marked)
1 ☐ Self Abusive
2 ☐ Assaultive
3 ☐ Provocative
4 ☐ Accidental
5 ☒ Other Specify in #21)

20. WHAT CORRECTIVE OR OTHER ACTIONS HAVE BEEN TAKEN?
1 ☐ Medical Treatment
2 ☐ Subject Relocated
3 ☐ Staff Relocated
4 ☐ Maintenance Request
5 ☐ Plan Modification
6 ☐ Observation of Subject
7 ☐ Supervision of Subject
Other (Explain): NURSES

21. DESCRIPTION OF INCIDENT: If report is completed by someone other than the one with first knowledge of situation, attach written report of that party and reports from any others involved.
(1) Describe incident and include address if different from 2, 4 or 22 (2) Give names of witnesses and others involved (3) Specify first aid (if given)

at 3:00 When I Came To Work I found V.Y in it Wheel Chair I Tried To Talk her out the Chair but She cannot Stand up alone, and have a hard Time Taking steps, and will slide to the floor She cannot Walk.

If take down was used: One Person _____ Two Persons _____ Face up _____ Other _____ (Describe)
If time-out was used as an approved intervention, indicate Time In _____ Time Out _____

22. SUBJECT'S PRESENT LOCATION (if different from residence)

	Title	Signature	Date
PRINT NAME OF PARTY COMPLETING THIS FORM: Lillian Thomas	DA II	Lillian Thomas	6-24-03
24. PRINT NAME OF PARTY COMPLETING REVIEW: ANNA KENNEDY	Title: DA II	Signature: Anna Kennedy	Date: 6/24-03